State of Connecticut
Office of Health Care Access
CON Waiver of Replacement Equipment Request Form
Form 2040

All Applicants involved with the proposal must be listed for identification purposes. Complete Form 2040 and submit the completed form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full Legal Name		
Doing Business As		
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail		
What is the Applicant's Status: P for Profit or NP for Nonprofit		
Does the Applicant have Tax Exempt Status?	Yes No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.		
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail		
Contact Person's Telephone Number		
Contact Person's Fax Number		

Contact Person's e-mail Address		

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

_____

b. Location of proposal, identifying Street Address, Town and Zip Code:

_____

c. List each town this project is intended to serve:

_____

d. Estimated starting date for the project: _____

SECTION III. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

a. This proposal may be eligible for a waiver of replacement equipment from the Certificate of Need process because of the following:

Please check each criterion that applies.

☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.

Provide a copy of the Certificate of Need authorization approving the original equipment.

☐ The cost of the equipment is not to exceed $3,000,000.

Note: Each criterion above must be met (checked off) for the proposal to qualify for waiver of replacement equipment from the Certificate of Need process.

b. Existing and the Proposed Major Medical and/or Imaging Equipment:

Equipment Type	Name/ Model	Existing/ Proposed	Date of Acquisition	Cost per unit	Description (i.e. tesla, # of slices, etc.)

Note: Provide a copy of the vendor contract or quotation for the major medical/imaging equipment.

SECTION IV. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $_____

b. Please provide the following tentative capital expenditure/costs related to the proposal:

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Equipment - Fair Market Value of Leases	
Major Medical Equipment - Fair Market Value of Leases	
Non-Medical Equipment - Fair Market Value of Leases	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	**$**
Total Project Cost	
Capitalized Financing Costs (For Informational Purpose Only)	

***** Provide an itemized list of all non-medical equipment to be purchased and leased.

c. Check each applicable financing method or funding source to be used for the proposal:

☐ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION V. PROJECT DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5” X 11” sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services, examinations or procedures that are currently provided by the existing piece of equipment?

2. List the types of services, examinations or procedures that will be provided by the proposed replacement equipment.

3. Identify the current population served and the target population to be served?

4. Explain the reasons why the existing equipment needs to be replaced.

5. Identify the benefits of replacing the existing equipment with the proposed replacement equipment?

SECTION VI. AFFIDAVIT

To be completed by each Applicant

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the
(Organization Name)

information provided in this CON Waiver Form (2040) is true and accurate to

the best of my knowledge, and that _____
(Facility Name)

complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____